OMB Approved No. 2900-0779
Respondent Burden: 15 minutes

Department of Veterans Affairs

PROSTATE CANCER DISABILITY BENEFITS QUESTIONNAIRE

IMPORTANT - THE DEPARTMENT OF VETERANS AFFAIRS (VA) ***WILL NOT PAY or REIMBURSE*** ANY EXPENSES OR COST INCURRED IN THE PROCESS OF COMPLETING AND/OR SUBMITTING THIS FORM. PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN INFORMATION BEFORE COMPLETING FORM.

NAME OF PATIENT/VETERAN	PATIENT/VETERAN'S SOCIAL SECURITY NUMBER

NOTE TO PHYSICIAN - Your patient is applying to the U.S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the veteran's claim.

SECTION I - DIAGNOSIS

1A. DOES THE VETERAN NOW HAVE OR HAS HE/SHE EVER BEEN DIAGNOSED WITH PROSTATE CANCER?

☐ YES ☐ NO *(If "Yes," complete Item 1B)*

1B. PROVIDE ONLY DIAGNOSES THAT PERTAIN TO PROSTATE CANCER:

DIAGNOSIS # 1 -	ICD CODE -	DATE OF DIAGNOSIS -
DIAGNOSIS # 2 -	ICD CODE -	DATE OF DIAGNOSIS -
DIAGNOSIS # 3 -	ICD CODE -	DATE OF DIAGNOSIS -

1C. IF ADDITIONAL DIAGNOSES THAT PERTAIN TO PROSTATE CANCER, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

2. INDICATE STATUS OF THE DISEASE

☐ ACTIVE ☐ REMISSION

SECTION III - TREATMENT FOR PROSTATE CANCER

3. HAS THE VETERAN COMPLETED ANY TYPE OF TREATMENT FOR PROSTATE CANCER OR IS THE VETERAN CURRENTLY UNDERGOING ANY TYPE OF TREATMENT FOR PROSTATE CANCER (INCLUDING WATCHFUL WAITING)?

☐ YES ☒ NO *(If "Yes," specify treatment type)*

☐ NO TREATMENT OTHER THAN WATCHFUL WAITING

☐ SURGERY

☐ PROSTATECTOMY

☐ OTHER SURGICAL PROCEDURE (DESCRIBE): _____ (DATE OF SURGERY): _____

☐ RADIATION THERAPY (DATE OF COMPLETION OF TREATMENT OR ANTICIPATED DATE OF COMPLETION): _____

☐ BRACHYTHERAPY (DATE OF TREATMENT): _____

☐ ANTINEOPLASTIC CHEMOTHERAPY (DATES OF MOST RECENT TREATMENT): _____

☐ ANDROGEN DEPRIVATION THERAPY (HORMONAL THERAPY) (DATES OF MOST RECENT TREATMENT): _____

☐ OTHER THERAPEUTIC PROCEDURE AND/OR TREATMENT (DESCRIBE): _____

(DATE OF PROCEDURE): _____

(DATE OF COMPLETION OF TREATMENT OR ANTICIPATED DATE OF COMPLETION): _____

SECTION IV - RESIDUALS

4. DOES THE VETERAN HAVE ANY RESIDUALS DUE TO PROSTATE CANCER OR TREATMENT FOR PROSTATE CANCER?

☐ YES ☐ NO *(If "Yes," complete the following Items 4A through 4G)*

A. VOIDING DYSFUNCTION/INCONTINENCE

DOES THE VETERAN HAVE VOIDING DYSFUNCTION SECONDARY TO TREATMENT FOR PROSTATE CANCER *(Continual urine leakage post-surgical urinary diversion, urinary incontinence or stress incontinence)?*

☐ YES ☐ NO *(If "Yes," indicate veteran's use of absorbent material)*

☐ ABSORBENT MATERIAL NOT NECESSARY

☐ ABSORBENT MATERIAL CHANGED LESS THAN 2 TIMES PER DAY

☐ ABSORBENT MATERIAL CHANGED 2 TO 4 TIMES PER DAY

☐ ABSORBENT MATERIAL CHANGED MORE THAN 4 TIMES PER DAY

Is the use of an appliance required?

☐ YES ☐ NO

SECTION IV - RESIDUALS *(Continued)*

B. URINARY FREQUENCY

DOES THE VETERAN HAVE URINARY FREQUENCY?

☐ YES ☐ NO *(If "Yes," indicate daytime and nighttime voiding intervals)*

DAYTIME VOIDING INTERVALS:

- ☐ DAYTIME VOIDING INTERVAL GREATER THAN 3 HOURS
- ☐ DAYTIME VOIDING INTERVAL BETWEEN 2 AND 3 HOURS
- ☐ DAYTIME VOIDING INTERVAL BETWEEN 1 AND 2 HOURS
- ☐ DAYTIME VOIDING INTERVAL LESS THAN 1 HOUR

NIGHTTIME VOIDING INTERVALS:

- ☐ NIGHTTIME AWAKENING TO VOID LESS THAN 2 TIMES
- ☐ NIGHTTIME AWAKENING TO VOID 2 TIMES
- ☐ NIGHTTIME AWAKENING TO VOID 3 TO 4 TIMES
- ☐ NIGHTTIME AWAKENING TO VOID 5 OR MORE TIMES

C. OBSTRUCTED VOIDING

DOES THE VETERAN HAVE OBSTRUCTED VOIDING?

☐ YES ☐ NO *(If "Yes," check all that apply)*

- ☐ OBSTRUCTIVE SYMPTOMATOLOGY WITH OR WITHOUT STRICTUREDISEASE REQUIRING DILATATION 1 TO 2 TIMES PER YEAR
- ☐ MARKED OBSTRUCTIVE SYMPTOMATOLOGY
- ☐ MARKED HESITANCY
- ☐ MARKEDLY SLOW OR WEAK STREAM
- ☐ MARKEDLY DECREASED FORCE OF STREAM
- ☐ POST VOID RESIDUALS GREATER THAN 150cc
- ☐ MARKEDLY DIMINISHED PEAK FLOW RATE ON UROFLOWMETRY *(less than 10cc/sec)*
- ☐ RECURRENT URINARY TRACT INFECTIONS SECONDARY TO OBSTRUCTION
- ☐ STRICTURE DISEASE REQUIRING PERIODIC DILATATION EVERY 2 TO 3 MONTHS
- ☐ URINARY RETENTION REQUIRING INTERMITTENT OR CONTINUOUS CATHETERIZATION

D. URINARY TRACT INFECTIONS

DOES THE VETERAN HAVE A HISTORY OF URINARY TRACT INFECTIONS?

☐ YES ☐ NO *(If "Yes," does the veteran have a history of recurrent symptomatic infections requiring any of the following?) (Check all that apply)*

- ☐ NONE
- ☐ DRAINAGE
- ☐ FREQUENT HOSPITALIZATION *(greater than 2 times per year)*
- ☐ CONTINUOUS INTENSIVE MANAGEMENT
- ☐ LONG-TERM DRUG THERAPY
- ☐ 1-2 HOSPITALIZATIONS PER YEAR
- ☐ INTERMITTENT INTENSIVE MANAGEMENT

E. ERECTILE DYSFUNCTION

DOES THE VETERAN HAVE ERECTILE DYSFUNCTION?

☐ YES ☐ NO

(If "Yes," is the erectile dysfunction as likely as not (at least a 51% probability) attributable to prostate cancer (including treatment or residuals)? ☐ YES ☐ NO *(If "No," provide the etiology of the erectile dysfunction):* _____

(If "Yes," is the veteran able to achieve an erection (without the use of medication) sufficient for penetration and ejaculation) ☐ YES ☐ NO

F. RENAL DYSFUNCTION

DOES THE VETERAN HAVE RENAL DYSFUNCTION ATTRIBUTABLE TO PROSTATE CANCER OR TREATMENT FOR PROSTATE CANCER?

☐ YES ☐ NO *(If "Yes," complete VA Form 21-0960J-4, Genitourinary/Renal Dysfunction Questionnaire)*

G. OTHER COMPLICATIONS

DOES THE VETERAN HAVE ANY OTHER RESIDUAL COMPLICATIONS?

☐ YES ☐ NO *(If "Yes," describe):*

SECTION V - FUNCTIONAL IMPACT AND REMARKS

5. DOES THE VETERAN'S PROSTATE CANCER IMPACT HIS ABILITY TO WORK?

☐ YES ☐ NO *(If "Yes," describe impact, providing one or more examples)*

6. REMARKS *(If any)*

SECTION VI - PHYSICIAN'S CERTIFICATION AND SIGNATURE

CERTIFICATION - To the best of my knowledge, the information contained herein is accurate, complete and current.

7A. PHYSICIAN'S SIGNATURE	7B. PHYSICIAN'S PRINTED NAME	7C. DATE SIGNED

7D. PHYSICIAN'S PHONE AND FAX NUMBER.	7E. PHYSICIAN'S MEDICAL LICENSE NUMBER	7F. PHYSICIAN'S ADDRESS
		Please refer to attachment for Physician's address

NOTE - VA may request additional medical information, including additional examinations, if necessary to complete VA's review of the veteran's application.

IMPORTANT - Physician please fax the completed form to 1-304-726-7368

(VA Regional Office FAX No.)

NOTE - A list of VA Regional Office FAX Numbers can be found at www.vba.va.gov/disabilityexams or obtained by calling 1-800-827-1000.

PRIVACY ACT NOTICE: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58/VA21/22/28, Compensation, Pension, Education and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by a Federal Statute of law in effect prior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine maximum benefits under the law. The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies.

RESPONDENT BURDEN: We need this information to determine entitlement to benefits (38 U.S.C. 501). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 15 minutes to review the instructions, find the information, and complete the form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

Provide Rationale if Prostate Cancer is not diagnosed

1C. (Cont) IF ADDITIONAL DIAGNOSES THAT PERTAIN TO PROSTATE CANCER, LIST USING ABOVE FORMAT.

4D. URINARY TRACT INFECTIONS

Drainage: |__| 1 or 2 times per year |__| > 2 times per year

Other Treatment, describe:

4E. (Cont.) PROVIDE THE ETIOLOGY OF THE ERECTILE DYSFUNCTION:

7F. (Cont) PHYSICIAN'S ADDRESS

Section V. Functional Impact

Section V. Remarks